No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his Official Capacity as Chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR *AMICI CURIAE* NATIONAL GOVERNORS ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERNMENTS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AND ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, IN SUPPORT OF PETITIONER

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CASES Page(s)

Alessi v. Raybestos-Manhattan, Inc.,
451 U.S. 504 (1981)..... 19, 20, 25

California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.,
519 U.S. 316 (1997).....*passim*

DeBuono v. NYSA-ILA Medical and Clinical Services Fund,
520 U.S. 806 (1997).....*passim*

District of Columbia v. Greater Washington Bd. of Trade,
506 U.S. 125 (1992)..... 26

Egelhoff v. Egelhoff ex rel. Breiner,
532 U.S. 141 (2001)..... 25

FMC Corp. v. Holliday,
498 U.S. 52 (1990)..... 19, 20, 25

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987)..... 17

Gobeille v. Liberty Mut. Ins. Co.,
135 S. Ct. 2887 (2015)..... 5

Hillsborough County, Fla. v. Automated Med. Labs., Inc.,
471 U.S. 707 (1985)..... 16

Ingersoll-Rand Co. v. McClendon,
498 U.S. 133 (1990)..... 19

TABLE OF AUTHORITIES—Continued

Page(s)

Kentucky Ass'n of Health Plans, Inc., v. Miller,
538 U.S. 329 (2003) 9

Liberty Mut. Ins. Co. v. Donegan,
746 F.3d 497 (2d Cir. 2014) ..... *passim*

Massachusetts v. Morash,
490 U.S. 107 (1989) 22

Metropolitan Life Ins. Co. v. Massachusetts,
471 U.S. 724 (1985) 25

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995) ..... *passim*

Shaw v. Delta Air Lines, Inc.,
463 U.S. 85 (1983) 19, 20, 25

STATUTES

29 U.S.C. §§ 1021-1030 ..... 17, 22

29 U.S.C. § 1143 22

29 U.S.C. § 1144(a) 18, 19

29 U.S.C. § 1144(b)(2)(A) 9

National Health Planning and Resources Development Act of 1974 (NHPRDA). Pub. L. 93-641, 88 Stat. 2225, §§ 1-3, repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3799 23

TABLE OF AUTHORITIES—Continued

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ARK. CODE ANN. § 23-61-901	8
COLO. REV. STAT. § 25.5-1-204	8
CONN. GEN. STAT. § 38a-1091	8
CONN. GEN. STAT. § 19a-724(f) (2013)	9
KAN. STAT. ANN. § 65-6804	8
ME. REV. STAT. ANN. tit. 22, §§ 8703, 8704	8
MD. CODE ANN., Health-Gen. § 19-133	8
MASS. GEN. LAWS ANN. ch. 12C, § 12	8
MINN. STAT. ANN. § 62U.04	8
N.H. REV. STAT. ANN. § 420-G:11-a	8
N.Y. PUB. HEALTH LAW § 2816	8
OR. REV. STAT. § 442.466	8
R.I. GEN. LAWS § 23-17.17-10	8
TENN. CODE ANN. § 56-2-125	8
UTAH CODE ANN. § 26-33a-106.1	8
VT. STAT. ANN. tit. 18, § 9410	8
VA. CODE ANN. § 32.1-276.7:1	8
WASH. REV. CODE. ANN. 43.371.010	8
W. VA. CODE § 33-4A-2	8

TABLE OF AUTHORITIES—Continued

COURT FILINGS Page(s)

Brief for Acting Secretary of the United States Department of Labor as Amicus Curiae Supporting Defendant-Appellee (Gobeille), *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014) (No. 12-4881) 16, 17, 22

Memorandum in Support of its Motion for Summary Judgment. *Liberty Mut. Ins. Co. v. Donegan*, No. 2:11-cv-204 (June 25, 2012) 20

OTHER AUTHORITIES

APCD COUNCIL, ALL-PAYER CLAIMS DATABASE DEVELOPMENT MANUAL (Mar. 2015), *available at* https://www.apcdcouncil.org/manual 10, 11

APCD COUNCIL, MODEL APCD LEGISLATION (May 2015), *available at* https://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation 10, 18

Beth Kuscher, *How New Hampshire Took the Guesswork Out of Healthcare Costs*, MODERN HEALTHCARE (July 16, 2015), *available at* https://www.modernhealthcare.com/article/20150716/NEWS/150719922 14

TABLE OF AUTHORITIES—Continued

Page(s)

CONSTANTIJN PANIS & MICHAEL BRIEN, SELF-INSURED HEALTH BENEFIT PLANS 2015 BASED ON FILINGS THROUGH STATISTICAL YEAR 2012 (2014), *available at* http://www.dol.gov/ebsa/pdf/ACASelfFundedHealth PlansReport2015.pdf 16

CTR. FOR HEALTH INFO. AND ANALYSIS & HEALTH POLICY COMM'N, MASSACHUSETTS COMMERCIAL MEDICAL CARE SPENDING: FINDINGS FROM THE ALL-PAYER CLAIMS DATABASE 2010-2012 MEDICAL CLAIMS PAYMENTS FOR THE THREE LARGEST COMMERCIAL PAYERS (July 2014), *available at* https://www.mass.gov/anf/docs/hpc/apcd-alma nac-chartbook.pdf 13

DENISE LOVE & CLAUDIA STEINER, KEY STATE HEALTH CARE DATABASES FOR IMPROVING HEALTH CARE DELIVERY (Feb. 2011), *available at* http://www.apcdcouncil.org/publication/key-state-health-care-databases-improving-health-care-delivery 5

Elizabeth Cohen, *How to Save Money on Health Care*, CNN, (Mar. 4, 2010), *available at* https://www.cnn.com/2010/HEALTH/03/04/medical.waste/ 14

H. James, Roderick Hudson (New York ed., World's Classics 1980) 18

TABLE OF AUTHORITIES—Continued

Page(s)

Healthcare Claims Indicator Report Module, NH HEALTH WRQS, https://www.nhhealthwrqs.org/HealthWRQS2?SubSystem=CLAIMS (last visited Aug. 27, 2015) 12

Interactive State Report Map, APCD COUNCIL, http://www.apcdcouncil.org/state/map (last visited Aug. 27, 2015)..... 9

KATHARINE LONDON ET AL., ANALYSIS OF PRICE VARIATIONS IN NEW HAMPSHIRE HOSPITALS (Apr. 2012), *available at* http:// www.nh.gov/insurance/lah/documents/umms.pdf 12

Medical Expenditure Panel Survey Household Component, 2014, CTR. FOR FIN., ACCESS, AND COST TRENDS, AGENCY FOR HEALTH-CARE RESEARCH AND QUALITY, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2014/alltables.pdf (last visited Aug. 27, 2015) 7

MINN. DEP'T OF HEALTH, AN INTRODUCTORY ANALYSIS OF POTENTIALLY PREVENTABLE HEALTH CARE EVENTS IN MINNESOTA (2015), *available at* http://www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf..... 13

TABLE OF AUTHORITIES—Continued

Page(s)

Nat'l Program of Cancer Registries, About the Program, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/cancer/npcr/about.htm (last visited Aug. 27, 2015) 5

Nat'l Vital Statistics Sys., About the Nat'l Vital Statistics Sys., CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/nchs/nvss/about_nvss.htm (last visited Aug. 27, 2015)..... 5

NEW HAMPSHIRE COMPREHENSIVE HEALTH CARE INFO. SYS., ADULT PREVENTIVE HEALTH CARE IN NEW HAMPSHIRE ISSUE BRIEF – JUNE 2009, *available at* http://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf (last visited Aug. 27, 2015) 12

NH HEALTHCOST, https://www.nhhealthcost. org (last visited Aug. 27, 2015) 13, 14

MAINE HEALTHCOST, https://mhdo.maine.gov/healthcost2014/CostCompare (last visited Aug. 27, 2015) 13

TABLE OF AUTHORITIES—Continued

Page(s)

Office-based Medical Provider Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012, All Office-based Medical Provider Services, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_G&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015) 7

PATRICK MILLER ET AL., ISSUE BRIEF: UTILIZATION AND COSTS FOR ADVERSE DRUG REACTIONS IN MAINE AND NEW HAMPSHIRE: 2005-2007 (2009), *available at* https://chhs.unh.edu/sites/chhs.unh.edu/files/docs/nhihpp/2009_09_03ADEIssueBrief.pdf 13

S. REP. NO. 93-127, 93th Cong., 2nd Sess. 1974, 1974 U.S.C.C.A.N. 4838, 4863..... 22

TABLE OF AUTHORITIES—Continued

Page(s)

Standards, APCD COUNCIL, https://www.apcdcouncil.org/standards (last visited Aug. 27, 2015) 15, 18

Total Health Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States 2012, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *available at* http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015) 7

TABLE OF AUTHORITIES—Continued

Page(s)

Understanding of the Efficiency and Effectiveness of the Health Care System, THE DARTMOUTH ATLAS OF HEALTH CARE, http://www.dart mouthatlas.org (last visited Aug. 27, 2015) 6

Wilson Andrews et al., *Disparity in Medical Billing*, WASHINGTON POST (May 8, 2013), *available at* http://www.washingtonpost.com/wp-srv/special/national/actual-cost-of-medical-care 6

INTEREST OF *AMICI CURIAE*[1]

Amici are organizations whose members include state governments and officials from across the country. *Amici* regularly file briefs in matters like this one, which raise issues of concern to the Nation's States.

The National Governors Association ("NGA"), founded in 1908, is the collective voice of the Nation's governors. NGA's members are the governors of the fifty States, three Territories, and two Commonwealths.

The National Conference of State Legislatures ("NCSL") is a bipartisan organization that serves the legislators and staffs of the Nation's fifty States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. NCSL advocates for the interests of state governments before Congress and federal agencies, and regularly submits *amicus* briefs to this Court in cases, like this one, that raise issues of vital state concern.

The Council of State Governments ("CSG") is the Nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders, collaborate, and create problem-solving partnerships.

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[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than the *amici curiae* or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Petitioner and Respondent have filed blanket consents to the filing of *amicus curiae* briefs in this case.

The National Association of Insurance Commissioners ("NAIC"), founded in 1871, is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight. The NAIC members, together with the centralized resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The Association of State and Territorial Health Officials ("ASTHO") is the national nonprofit organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ. ASTHO members, the chief health officials of these jurisdictions, formulate and influence sound public health policy and ensure excellence in state-based public health practice. ASTHO's primary function is to track, evaluate, and advise members on the impact and formation of public or private health policy which may affect states and to provide them with guidance and technical assistance on improving the nation's health.

This case directly impacts the interests of *amici* and their members. States across the country—through members of the *amici* organizations, which include the governors, legislatures, insurance commissioners, public health officials, and other state officials—are working to ensure that citizens have access to quality and affordable health care services. This is a task for which states have traditionally been responsible—rising to the level of an "historic police power." In an effort to better understand the provision of health care

services, track related expenses and provide transparency to consumers, providers, and payers, many states have implemented databases similar to the one established by Vermont. States have long-relied on the assumption that the federal government would not interfere with their historic police powers in the field of health care policy. In implementing these databases, states depend on the strong presumption against ERISA preemption to guarantee they are collecting complete and reliable data from *all* health care service payers. *Amici*, thus, have a strong interest in the outcome of this case.

SUMMARY OF ARGUMENT

Eighteen states, including Vermont, collect and analyze health care claims data to regulate the safe and effective provision of health care services. The data collected provides states with critical information about the health of their citizens and contributes to their understanding of health care utilization, cost, and quality. The information gathered can be used for a variety of purposes, allowing consumers to shop for the lowest cost and highest quality care, insurers to negotiate acceptable rates, and lawmakers to establish tailored health care policy initiatives. But without data from *all* health care payers, including self-insured plans (which cover nearly 70 million participants) the completeness, and therefore usefulness, of the data would be compromised.

ERISA does not preempt these health care data collection laws. In enacting these laws, states are exercising their historic and traditional police power to ensure the health and safety of their citizens. Accordingly, this Court should apply the presumption against preemption to these laws. Liberty Mutual has provided no evidence to overcome this presumption.

These laws apply generally to *all* health care payers and do not relate to ERISA plans. They do not interfere or conflict with the "reporting" required by ERISA, which is predominantly concerned with the financial solvency of the plans and not the health care outcomes of their beneficiaries. Additionally, there is no indication that Congress meant to supersede these types of laws, particularly in light of a federal law enacted only months after ERISA encouraging states to seek much of the same data collected by Vermont and other states. Furthermore, the state data collection laws do not mandate benefit structures or administration, nor do they provide an enforcement mechanism. And while there may be incidental costs involved with providing the data, these costs alone do not render a state law preempted by ERISA.

The Second Circuit misapplied long-standing ERISA preemption case law. Left uncorrected, this ruling will negatively impact health care policy across the country.

ARGUMENT

I. ERISA Preemption is Inappropriate

This Court repeatedly has held that there is a presumption that Congress does not intend to supplant state law, particularly in areas of traditional state regulation. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 657 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 334 (1997); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 814-15 (1997). In the case below, the Second Circuit rejected this presumption, confining its analysis to a footnote in which it concluded, without citation, that the "state

data collection laws do not regulate the safe and effective provision of health care services, which is among the states' historic police powers." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 506 n.8 (2d Cir. 2014), *cert. granted sub nom. Gobeille v. Liberty Mut. Ins. Co.*, 135 S. Ct. 2887 (2015). The *amici* joined in this brief disagree with this conclusion and defend the legitimate use of state police powers to collect health care data.

A. Health Care Data Collection Laws Fill Critical Information Gaps for States

States are regulators, suppliers, payers and customers of the health care delivery system. States need access to high quality, consistently-collected data reflecting health care use to support effective health policy development, understand health system use, and drive health delivery reform. Unsurprisingly, for many years, states have been innovators in data collection to support these health care improvement efforts.

Historically, state health care data collection has been limited. Currently, most states maintain: state-based hospital discharge systems;[2] cancer registry systems;[3] and vital records systems.[4] These data are useful but because they are limited they cannot be aggregated and analyzed to answer many basic and

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[2] DENISE LOVE & CLAUDIA STEINER, KEY STATE HEALTH CARE DATABASES FOR IMPROVING HEALTH CARE DELIVERY (Feb. 2011), *available at* http://www.apcdcouncil.org/publication/key-state-health-care-databases-improving-health-care-delivery.

[3] *Nat'l Program of Cancer Registries, About the Program*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/cancer/npcr/about.htm (last visited Aug. 27, 2015).

[4] *Nat'l Vital Statistics Sys., About the Nat'l Vital Statistics Sys.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/nchs/nvss/about_nvss.htm (last visited Aug. 27, 2015).

helpful questions that could improve health care quality, access, and cost. Hospital discharge data, for example, are used broadly and in many different ways, including studying patterns of care in the inpatient setting, understanding rates of hospitalization for disease and injury, and exploring patient characteristics for different hospitals. Data all states currently collect can also reveal information about costs for services, which can be used by health care consumers. For instance, certain hospital inpatient data has shown the disparity in costs charged for various procedures in hospitals across the country.[5] To illustrate, data from 2011 showed that one Miami hospital charged $127,038 to implant a pacemaker, while a hospital down the street charged only $66,030. *Id.*

Until recently states have not collected similar data for office-based and other outpatient care ("ambulatory care") except for Medicare[6] and Medicaid patients,[7] although the majority of health care in the United

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[5] Wilson Andrews et al., *Disparity in Medical Billing*, WASHINGTON POST (May 8, 2013), *available at* http://www.washingtonpost.com/wp-srv/special/national/actual-cost-of-medical-care.

[6] Regarding ambulatory care, the Centers for Medicare and Medicaid Services collects and makes available data based on claims paid by Medicare, which includes those 65 and older and those with certain medical conditions. While these data have been used to provide a robust understanding of patterns of care, the data are limited to that population. *Understanding of the Efficiency and Effectiveness of the Health Care System*, THE DARTMOUTH ATLAS OF HEALTH CARE, http://www.dartmouthatlas.org (last visited Aug. 27, 2015).

[7] State-based Medicaid data also provide a wealth of information about the type, quality, and cost of care for that population. But, like Medicare data, Medicaid data reflects only a small, albeit very important, portion of the population, including low-income parents, children and people with disabilities.

States is provided in these settings.[8] For this reason, states have begun implementing health care data collection laws like Vermont's.

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[8] In 2012, 72.4% of the U.S. population had a health care expense related to an office visit. *Office-based Medical Provider Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012, All Office-based Medical Provider Services*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_G&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015). The percentage of the population with inpatient hospital, outpatient hospital, or emergency room expense was much lower: 7.5%, 15.8%, and 12.9%, respectively. *Id.* In 2014, only around 20% of the population was covered by public insurance (e.g., Medicare and Medicaid), while approximately 60% were covered by private insurance. *Medical Expenditure Panel Survey Household Component, 2014*, CTR. FOR FIN., ACCESS, AND COST TRENDS, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2014/alltables.pdf (last visited Aug. 27, 2015). Further, nearly half of all medical expenses were paid for by private insurance in 2012. *Total Health Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States 2012*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *available at* http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015).

1. Development of State Health Care Data Collection Laws

Recognizing the need for broad-based, health system-wide data to understand key health issues, states began creating All-Payer Claims Databases ("APCDs"), like Vermont's, which hold the potential for a much deeper understanding of patterns, quality, and cost of care across the entire population. In 2007, the Regional All-Payer Healthcare Information Council began as a convening organization to bring together several Northeast states that had, or were developing, APCD systems. The vision was to support cross-state data harmonization and analytic activities. The organization quickly expanded to include states across the country to address a wider variety of activities, such as sharing of processes, addressing common challenges in data acquisition, and identifying resources that could be leveraged across states. In 2010, the organization became the All-Payer Claims Database Council ("APCD Council") to reflect the expanded reach.

As of August 2015, 18 states have enacted legislation creating these health care databases ("state health care data collection laws" or "APCD laws").[9] Currently, there are 14 states with existing APCDs, 4 in implementation, 3 existing voluntary efforts, and at least 5 other

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[9] ARK. CODE ANN. § 23-61-901; COLO. REV. STAT. § 25.5-1-204; CONN. GEN. STAT. § 38a-1091; KAN. STAT. ANN. § 65-6804; ME. REV. STAT. ANN. tit. 22, §§ 8703, 8704; MD. CODE ANN., Health-Gen. § 19-133; MASS. GEN. LAWS ANN. ch. 12C, § 12; MINN. STAT. ANN. § 62U.04; N.H. REV. STAT. ANN. § 420-G:11-a; N.Y. PUB. HEALTH LAW § 2816; OR. REV. STAT. § 442.466; R.I. GEN. LAWS § 23-17.17-10; TENN. CODE ANN. § 56-2-125; UTAH CODE ANN. § 26-33a-106.1; VT. STAT. ANN. tit. 18, § 9410; VA. CODE ANN. § 32.1-276.7:1; WASH. REV. CODE. ANN. 43.371.010; W. VA. CODE § 33-4A-2.

states with interest in developing an APCD.[10] The health care claims-payment data that states collect can be used to analyze health care utilization, cost, quality, and population health, as well as to support health care reform initiatives. Some states also focus on transparency for consumers,[11] to better inform the populace of the true costs of health care services. Two states also use the data to regulate the rates that health insurance companies charge consumers.[12]

In an effort to harmonize state activity around APCDs, the APCD Council has worked with states across the country on a variety of matters related to APCD development, including: coordinating stakeholder meetings; reviewing legislation; assisting with rule

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[10] *Interactive State Report Map*, APCD COUNCIL, http://www.apcdcouncil.org/state/map (last visited Aug. 27, 2015).

[11] *See, e.g.*, CONN. GEN. STAT. § 19a-724(f) (2013).

[12] New Hampshire currently uses the data to regulate rates, while Arkansas recently transferred its data collection efforts to the insurance rate review section, to facilitate their use of the data to regulate insurance rates. Laws like those of New Hampshire and Arkansas may be afforded further protection from preemption under ERISA's savings clause which provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). To be saved from preemption, a state law must (1) be "specifically directed toward entities engaged in insurance," and (2) "substantially affect the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans, Inc., v. Miller*, 538 U.S. 329, 342 (2003). If a state's data collection law is used to inform a state's health insurance rate review process or administration of risk adjustment, it would substantially affect the risk pooling arrangement between insurers and insureds because it would dictate the rates that an insurer may charge, and thereby alter the scope of permissible bargains between insurers and insureds.

development; assisting with vendor selection; providing analytics support; linking states to one another to find common solutions; and leveraging state resources to achieve common objectives. Among the APCD Council's efforts is publication of a manual that provides a framework for states to develop their own APCDs.[13] In addition, the APCD Council published model legislation to encourage legal consistency among states.[14]

2. Data are Used for a Variety of Purposes

APCDs are unique administrative datasets that contain information, across all payers, for all ages, in one database, and can supplement the information available through other more limited and restricted data sources. These databases generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. Given the breadth of APCDs, analysis of these data can answer many important health services research questions for policy makers, consumers, employers, providers, insurers, and researchers. Research and policy questions that can be answered using APCDs include:

- Which providers have the highest prices?
- How far do people travel for services? Which services are they travelling for?
- Which parts of the state have better access to specialists?

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[13] APCD COUNCIL, ALL-PAYER CLAIMS DATABASE DEVELOPMENT MANUAL (Mar. 2015), *available at* https://www.apcdcouncil.org/manual.

[14] APCD COUNCIL, MODEL APCD LEGISLATION (May 2015), *available at* https://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation.

- Which parts of the state have better access to dental care?
- Are services for mental health, substance use, or primary care available in rural areas?
- What are the drivers of high cost patients and hospital readmissions?
- If emergency room usage in Medicaid is higher than in the commercially-insured population, what are the drivers?
- What are the utilization patterns and rates for Medicaid compared to commercial insurance?
- What are the testing, treatment, and screening trends for communicable diseases? What are the gaps in disease prevention and health promotion services?
- What percentage of the population has had a mammogram?
- What is the average length of time people are using antidepressant medications and what are the patient demographics?

States are developing APCD reporting systems to fill these critical information gaps, to ensure accessibility of data to a broad variety of users, to promote health care transparency initiatives, to improve administrative simplification in the provision of health care services, and to provide actionable information for their stakeholders.[15]

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[15] APCD COUNCIL, ALL-PAYER CLAIMS DATABASE DEVELOPMENT MANUAL (Mar. 2015), *available at* https://www.apcdcouncil.org/manual.

Examples of ways that states have used APCDs are described below.

Pricing Variation: A New Hampshire report released in the fall of 2007 and updated in 2012 uses both APCD data as well as hospital discharge data to look at pricing of inpatient and outpatient services in the state.[16]

Preventive Health Care Services in Medicaid: The New Hampshire Office of Medicaid Business and Policy has published a report comparing the use of preventive health services for those covered by Medicaid versus commercial insurance. The findings of the study highlight opportunities for improvement in the use of preventive services (e.g., cancer screening, asthma medication) in the Medicaid population.[17]

Disseminating Administrative Data: New Hampshire has a web-based reporting and query system, known as HealthWRQS, for the dissemination of data collected systematically by state agencies for public health purposes. It provides community-level information about the burden of cardiovascular disease and mental illness, and the treatment of those conditions.[18]

Burden of Adverse Drug Events: Researchers in Maine and New Hampshire analyzed data from the

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[16] KATHARINE LONDON ET AL., ANALYSIS OF PRICE VARIATIONS IN NEW HAMPSHIRE HOSPITALS (Apr. 2012), *available at* http://www.nh.gov/insurance/lah/documents/umms.pdf.

[17] NEW HAMPSHIRE COMPREHENSIVE HEALTH CARE INFO. SYS., ADULT PREVENTIVE HEALTH CARE IN NEW HAMPSHIRE ISSUE BRIEF – JUNE 2009, *available at* http://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf (last visited Aug. 27, 2015).

[18] *Healthcare Claims Indicator Report Module*, NH HEALTH WRQS, https://www.nhhealthwrqs.org/HealthWRQS2?SubSystem=CLAIMS (last visited Aug. 27, 2015).

APCDs of those states to determine the scope and costs associated with adverse drug events.[19]

Health Care Delivery Efficiency Improvement: The Minnesota APCD is used to assess the opportunities for greater health care efficiencies.[20]

Spending Trends in Health Care: Massachusetts relies upon the APCD data to develop an annual report examining trends in commercial medical spending including overall spending trends and spending by category of service, type of episode, and region using data from the Massachusetts APCD.[21]

Health Cost Transparency: Price transparency websites that contain comparison prices for a variety of common healthcare procedures allow consumers and employers to identify accessible low cost providers in their area for health care services. Examples include NH HealthCost[22] and Maine HealthCost.[23] Like Maine

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[19] PATRICK MILLER ET AL., ISSUE BRIEF: UTILIZATION AND COSTS FOR ADVERSE DRUG REACTIONS IN MAINE AND NEW HAMPSHIRE: 2005-2007 (2009), *available at* https://chhs.unh.edu/sites/chhs.unh.edu/files/docs/nhihpp/2009_09_03ADEIssueBrief.pdf.

[20] MINN. DEP'T OF HEALTH, AN INTRODUCTORY ANALYSIS OF POTENTIALLY PREVENTABLE HEALTH CARE EVENTS IN MINNESOTA (2015), *available at* http://www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf.

[21] CTR. FOR HEALTH INFO. AND ANALYSIS & HEALTH POLICY COMM'N, MASSACHUSETTS COMMERCIAL MEDICAL CARE SPENDING: FINDINGS FROM THE ALL-PAYER CLAIMS DATABASE 2010-2012 MEDICAL CLAIMS PAYMENTS FOR THE THREE LARGEST COMMERCIAL PAYERS (July 2014), *available at* https://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf.

[22] NH HEALTHCOST, https://www.nhhealthcost.org (last visited Aug. 27, 2015).

[23] MAINE HEALTHCOST, https://mhdo.maine.gov/healthcost2014/CostCompare (last visited Aug. 27, 2015).

and New Hampshire, several states cater directly to health care consumers.[24] And consumers are experiencing direct benefits from cost transparency. For example, when a six-year-old girl cut her eyebrow and needed stitches, the girl's mother was able to compare emergency room costs for that procedure on the NH HealthCost website. *Id.* She used the data to save $500 by driving to a hospital 20 minutes further than the one closest to her home. *Id.* Insurers are using the health care cost data too. The largest health insurer in New Hampshire was able to renegotiate a hospital contract after discovering that the hospital was charging rates that were 50% higher than other hospitals.[25]

3. Data Collection and Reporting is Standardized and Routine

States have developed APCDs by leveraging existing data systems in place for the claims adjudication processes, i.e., the processes by which claims are submitted to and paid by health insurers. State-based claims data systems collect data from the commercial carriers' data storage systems. Providers of care and payers exchange data on these systems for the purposes of adjudication. The state APCDs collect data elements that are typically part of the adjudication process for both private and public payers, such as Centers for Medicare and Medicaid Services (CMS).

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[24] Elizabeth Cohen, *How to Save Money on Health Care*, CNN, (Mar. 4, 2010), *available at* https://www.cnn.com/2010/HEALTH/03/04/medical.waste/.

[25] Beth Kuscher, *How New Hampshire Took the Guesswork Out of Healthcare Costs*, MODERN HEALTHCARE (July 16, 2015), *available at* http://www.modernhealthcare.com/article/20150716/NEWS/150719922.

Therefore, the collected data already exists and is readily accessible in the payer's system.

Because claims data are generated for billing purposes, the data elements are generally available across payer systems. Uniformity of data submission is important, both for reasons of comparability within and across states and to reduce the payers' burden to submit data to different states in different formats. To address these issues there are initiatives to standardize data reporting formats.[26] In fact, "[i]n 2010 and 2011, the APCD Council convened a Technical Advisory Panel to build consensus around the APCD data collection standardization process." *Id.* Several large health insurers participated on the panel including Aetna, Cigna, Humana, and Kaiser Permanente. *Id.* Early efforts in standardization have resulted in industry reporting standards that align with both state reporting needs and payer reporting capabilities. *Id.*

4. Data Completeness is Important

States have developed APCDs to answer important public health, public policy and health care market questions. The most accurate understanding of the population in a state comes from analyzing comparable data collected from the majority of the population. Therefore, availability of data from both the insured and self-insured population is critically important to states for health care planning, public policy and economic development.

In this case, Liberty Mutual seeks to avoid participation in this important data collection simply because it is a self-insured plan. If APCD laws are found to be preempted by ERISA, an employers' choice to self-

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[26] *Standards*, APCD COUNCIL, https://www.apcdcouncil.org/standards (last visited Aug. 27, 2015).

insure its workforce would result in a permanent lack of critical claims data necessary for the improvement of the health care system. The exclusion of data from self-insured plans is not insignificant. The number of participants in self-insured plans governed by ERISA has been increasing over the last several years. As of 2012, that number reached 69.8 million.[27]

B. The Presumption Against Preemption Applies

"[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough County, Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). Liberty Mutual must "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 814 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995)).

As an initial matter, the state data collection does not encroach on ERISA's objectives. *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325 (1997). The Second Circuit majority opinion mistakenly declares "reporting" to be a core ERISA function, *Donegan*, 746 F.3d at 508, without analyzing the distinction between the type of information required by the Department of Labor and that required by the state laws, and in direct contravention of the Department of Labor's position. Brief

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[27] CONSTANTIJN PANIS & MICHAEL BRIEN, SELF-INSURED HEALTH BENEFIT PLANS 2015 BASED ON FILINGS THROUGH STATISTICAL YEAR 2012 (2014), *available at* http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport2015.pdf.

for Acting Secretary of the United States Department of Labor as Amicus Curiae Supporting Defendant-Appellee (Gobeille) at 12-14, *Donegan*, 746 F.3d 497 (2d Cir. 2014) (No. 12-4881) [hereinafter DOL Second Circuit Amicus Brief]. The core functions of the ERISA statute are "determining the eligibility of claimants, calculating benefit levels, making disbursements, [and] monitoring the availability of funds for benefit payments." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). While plans are required to furnish reports, 29 U.S.C. §§ 1021-30, those reports relate to the provision of benefits to participants and the financial soundness of the plans (e.g., "monitoring the availability of funds for benefit payments").

As the Department of Labor made clear, it does not collect the data sought by the states, and there is no overlap between the reporting requirements of the federal and state governments. DOL Second Circuit Amicus Brief at 13 (the Vermont law "does not impose conflicting data collection or reporting requirements . . . and does not appreciably add to the burdens of complying with ERISA reporting requirements or serve the same purpose as ERISA's reporting regime").

The Second Circuit also found that the state laws are burdensome (albeit without any record support). *Donegan*, 746 F.3d at 509, 515. Liberty Mutual never presented evidence that complying with the law constituted a burden. In fact, its third-party administrator, which maintained the data, was by all accounts "happy to provide the data Vermont has asked for, and it does so for other clients." *Id.* at 515 (J. Straub, dissenting in part and concurring in part).

The APCD laws are not burdensome. They do not require any recordkeeping, and only require plans (along with all other health care payers) to report information

already in their possession. And while a multiplicity of reporting regimes theoretically could impact plans so adversely as to alter their benefit structure, states are working together, through the APCD Council and other entities, to minimize such burdens. For instance, a model law promotes uniformity for states enacting their own legislation. MODEL APCD LEGISLATION, *supra* note 14. And states have used existing claims adjudication processes as the basis for the reporting requirements, thereby limiting the impact of the administrative burden of compliance. *Standards*, *supra* note 26.

As a result, the presumption against preemption is not overcome, since the states' reporting laws are laws of general applicability with only incidental impact on ERISA plans. *Travelers*, 514 U.S. at 661.

II. State Health Care Data Collection Laws Do Not "Relate To" ERISA Plans

In recognition of the strong presumption against preemption, 20 years ago, this Court rejected its previously broad reading of ERISA's preemption clause. *Travelers*, 514 U.S. at 655 (1995). That clause, Section 514(a) of ERISA, 29 U.S.C. § 1144(a), preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The Travelers Court explained that the words of limitation ("insofar as they . . . relate") would effectively be limitless "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy[.]" *Travelers*, 514 U.S. at 655. If so, "preemption would never run its course, for 'really, universally, relations stop nowhere[.]" *Id.* (quoting H. James, Roderick Hudson xli (New York ed., World's Classics 1980)). This Court acknowledged that its "prior attempt[s] to construe the phrase 'relate to' d[id] not give [] much help drawing the line." *Id.*

at 655. Ultimately, *Travelers* stands for the "rejection of a strictly literal reading of § 514(a)." *DeBuono*, 520 U.S. at 813.

The New York statutes at issue in *Travelers* required hospitals to collect surcharges from patients covered by a commercial insurer but not from those insured by a nonprofit Blue Cross/Blue Shield plan. *Travelers*, 514 U.S. at 649. They also subjected certain health maintenance organizations to surcharges based on the number of Medicaid recipients they enrolled. *Id.* This Court determined that these laws did not "relate to" ERISA because they "affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Id.* at 668.

Even prior to *Travelers*, only two categories of state laws were found to be "related to," and, thus, preempted by, ERISA: "those that mandate employee benefit structures or their administration . . . and those providing alternative enforcement mechanisms." *Id.* at 657-8 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990)).

In *Shaw*, for example, the preempted state statutes "'relate[d] to' benefit plans" by "prohibit[ing] employers from structuring their employee benefit plans in a manner that discriminate[d] on the basis of pregnancy" and by "requir[ing] employers to pay employees specific benefits." *Travelers*, 514 U.S. at 657 (quoting *Shaw*, 463 U.S. at 97, 103). Likewise, a Pennsylvania antisubrogation law was found to be related to employee benefit plans because it "prohibited 'plans

from . . requiring reimbursement [from the beneficiary] in the event of recovery from a third party.'" *Id.* (quoting *Holliday*, 498 U.S. at 60). This resulted in some Pennsylvania employees recovering benefits in excess of what employees in other states received and prevented plan administrators from calculating "uniform benefit levels nationwide." *Id.* Similarly, a New Jersey law was found to be related to ERISA plans because it "prohibit[ed] plans from setting workers' compensation payments off against employees' retirement benefits or pensions because doing so would prevent plans from using a method of calculating benefits permitted by federal law." *Id.* (citing *Alessi*, 451 U.S. at 524).

The APCD laws at issue here do not implicate any of the concerns in the cases cited above. The APCD laws do not mandate employee benefit structures nor do they provide alternative enforcement mechanisms. They do not impose any conditions that would affect the contractual relationship among the involved parties. And their relationship to ERISA is even more indirect than the surcharges at issue in *Travelers* because APCD laws do not impose fees or taxes but simply seek already-existing information from *all* health care payers.

In deciding *Travelers*, this Court referred back to a pronouncement made more than 10 years previously, that a law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* at 656 (quoting *Shaw*, 463 U.S. at 96-97).[28] Determining

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[28] The issue of whether the Vermont law makes "reference to" ERISA is not before this Court. Liberty Mutual did not raise this point in its Memorandum in Support of its Motion for Summary Judgment in the district court or in its brief filed with the Second Circuit.

whether a law has a "connection with" ERISA plans can result in the same frustration as determining whether a law is "related to" ERISA plans since "infinite connections," like "infinite relations cannot be the measure of pre-emption." *Id.* at 656. Therefore, we look to "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive . . . as well as to the nature of the effect of the state law on ERISA plans.'" *Dillingham*, 519 U.S. at 325 (quoting *Travelers* at 658-59). This analysis is done under the "'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* In pursuing this line of inquiry, it is clear that the state APCD laws have no "connection with" ERISA plans.

A. Congress Did Not Intend ERISA to Supersede State Health Care Data Collection Laws

The Second Circuit Court of Appeals incorrectly seized on the fact that the federal law imposes "reporting" requirements on plan providers. *Donegan*, 746 F.3d at 508. But this "misses the nuance of what 'reporting'

A law contains an impermissible "reference to" ERISA plans, where it "acts immediately and exclusively upon ERISA plans . . or where the existence of ERISA plans is essential to the law's operation. *Dillingham*, 519 U.S. at 325 (citations omitted). The Vermont law and the other APCD laws apply generally to all providers, purchasers and insurers, including self-insured plans governed by ERISA. It cannot be said that these statutes contain a "reference to" ERISA plans. As laws applicable to "all payers," they do not "act[] immediately and exclusively upon ERISA plans." *Id.* at 325 (citations omitted). As laws of general application, "the existence of ERISA plans" is not "essential to the law[s'] operation." *Id.*

means in the context of ERISA." *Id.* at 511 (J. Straub, dissenting in part and concurring in part). ERISA plan administrators are required to provide a summary plan description to participants and to file an annual report with the Department of Labor. *See* 29 U.S.C. §§ 1021-1030. The summary plan description notifies participants of their rights and obligations under the plan, while the annual report seeks financial and actuarial information from the plan. *See id.* Among the purposes of these reports is to ensure that the plan is "operated according to instructions and in the best interests of participants and beneficiaries" and to enable participants "to know whether the plan [is] financially sound and being administered as intended." S. REP. NO. 93-127, 93th Cong., 2nd Sess. 1974, 1974 U.S.C.C.A.N. 4838, 4863.

While the Department of Labor is authorized "to undertake research and surveys and . . . to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans," 29 U.S.C. § 1143, the Department of Labor has stated that it does not collect any of the data states are collecting under these laws. DOL Second Circuit Amicus Brief at 12. In fact, Congress' primary concern, in enacting ERISA, "was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27; *Massachusetts v. Morash*, 490 U.S. 107, 115, 109 (1989). Based on this concern, Congress "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Morash*, 490 U.S. at 115.

Thus, the "reporting" mandated by Congress is of an entirely different nature and scope from the "reporting" required by the states. Congress is concerned with the solvency and viability of ERISA plans to ensure that participants and beneficiaries are guaranteed their benefits. States, on the other hand, are concerned with the nature, cost, and quality of health care services among *all* health care providers and carriers, which just happens to include ERISA plans among a number of other affected entities. There is no indication, in the law or legislative history that in enacting ERISA, Congress had the "clear and manifest purpose" of superseding the "historic police powers of the States" with regard to health care policy. *See Dillingham*, 519 U.S. at 325. "[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S.at 661 (citations omitted).

Of particular assistance in understanding ERISA's history is the fact that, just months after adopting ERISA, the same Congress adopted the National Health Planning and Resources Development Act of 1974 (NHPRDA). Pub. L. 93-641, 88 Stat. 2225, §§ 1-3, repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3799. "The NHPRDA sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health services." *Travelers*, 514 U.S. at 665 (citations omitted). The NHPRDA "provided for the organization and partial funding of regional 'health systems agencies' responsible for gathering data as well as for planning and developing health resources in designated health service areas." *Id.* In acknowledging the historic police powers of states in matters of health care policy, Congress asked the states to "gather data" in order to respond

to "growing health care costs." *Id.* This is precisely what states are currently doing with the APCD laws at issue here. Indeed, among the goals of the NHPRDA was establishing state agencies to "regulat[e] rates for the provision of health care." *Id.* at 666. Most states with health care databases are not even taking the extra step of "regulating rates" and are simply providing information to consumers, providers and others in an effort to promote efficiency, efficacy and transparency in the provision of health care services.

The *Travelers* Court compared the purposes and goals of the NHPRDA with New York's hospital surcharge laws, finding that "the statute[s'] provision for comprehensive aid to state health care rate regulation is simply incompatible with pre-emption of the same by ERISA." *Id.* at 667. Likewise, in comparing the purposes and goals of the NHPRDA with the state APCD laws, there can be no finding that Congress had any intention of preempting such laws.

B. State Health Care Data Collection Laws Do Not Interfere or Conflict with ERISA

In applying ERISA preemption, the Second Circuit focused on the fact that different states may collect different data leading to a lack of "national uniformity" in data collection that would be burdensome to self-insured plans. The Second Circuit explained that "[p]reemption 'was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law . . to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Donegan*, 746 F.3d at 504-05 (citations omitted). But uniformity in health care data reporting

is not the type of uniformity that ERISA is concerned with.

The statutes that have been found to interfere with national uniformity include those that "mandated employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. These preempted statutes have included the following: a law that prohibited "a method of calculating pension benefits that federal law permit[ted]"; a law that "required employers to provide certain benefits"; an antisubrogation law that "require[d] plan providers to calculate benefit levels . . based on expected liability conditions that differ[ed] from those" in other states; and a law that prevented administrators from "mak[ing] payments simply by identifying the beneficiary specified by the plan documents" and, instead required them to "familiarize themselves with state statutes so that they c[ould] determine whether the named beneficiary's status has been 'revoked' by operation of law." *DeBuono*, 520 U.S. at 814-15 (citing *Alessi*, 451 U.S. at 524-25; *Shaw*, 463 U.S. 85; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)); *Travelers*, 514 U.S. at 657-58 (quoting *Holliday*, 498 U.S. at 60); *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 142 (2001). These are the types of laws that "frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Holliday*, 498 U.S. at 60.

The state APCD laws at issue here have no impact whatsoever on an ERISA plan's calculation of benefit levels. Furthermore, states enacting these laws are seeking uniformity for reasons that have nothing to do with ERISA. It is to the states' advantage that they collect data in a similar manner so that eventually, the data can be compared with other states. The work of the APCD Council, including the issuance of its model

law, helps ensure that these laws are harmonized across the country. So, while states might request submission of different data fields from the *already existing* claims data held by plan administrators, this hardly rises to the level of conflict ERISA preemption seeks to avoid. Additionally, payers, providers and other data submitters have the opportunity to participate in the legislative process, to ensure that the burdens across borders are minimized.

Nor would the incidental costs involved with providing the data require preemption of the state APCD laws. "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *DeBuono*, 520 U.S. at 816. As the *Travelers* Court explained, "cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Travelers*, 514 U.S. at 662. "Pre-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992) (citations omitted). The state APCD laws, which are laws of general applicability have only a "tenuous, remote, or peripheral connection with covered plans" and, therefore, cannot be found to be preempted.

CONCLUSION

For these reasons, the judgment of the Second Circuit should be reversed.

Respectfully submitted,

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